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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXII NOVEMBER, 1952 No. 9

FACILITIES SURVEY DISCLOSES ONE-FIFTH OF PUPILS IN UNSAFE SCHOOLS*

A significant fraction of the nation's school buildings are unsafe when measured by fire resistive standards, are obsolete when measured by age and educational standards, and are overcrowded with pupils. These findings are made in the First Progress Report of the School Facilities Survey being conducted by the United States Office of Education under the direction of the Eighty-first Congress.

Almost seventy percent of the school buildings in the seventeen states, which have completed the study on fire resistiveness are combustible. More than six million pupils are enrolled in these schools.

"It is not implied," the report states, "that all school buildings should be fire resistive; however, it is recognized that fire resistive buildings are . . . less hazardous to children than are combustible buildings."

The School Facilities Survey is the first comprehensive attempt to arrive at a satisfactory agreement on the number and kinds of public elementary and secondary school facilities now available in the nation and to reach an acceptable estimate of the needs.

The responsible school authorities of forty-five states are partocipating in the survey. "States," in this connection, would include the District of Columbia, Alaska, Hawaii, Puerto Rico and the Virgin Islands. Actual responsibility for conducting the survey in a particular state rests with the state's own educational agency. The school housing section of the federal Office of Education has the responsibility of coordinating and summarizing the findings of the individual states.

A the time the First Progress Report was published forty-five states had made some degree of progress in their inventory of existing school facilities; eight were not yet participating. Seventeen states had completed that part of the inventory covering fire resistiveness.

School buildings are classified as to type of construction, being *Fire resistive*

* From Saftey Education for October 1952.

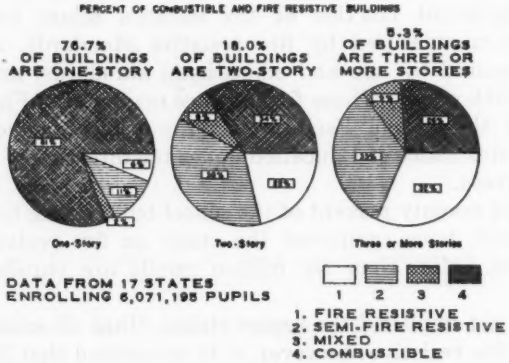
Semi-fire resistive

This includes buildings with fire resistive masonry walls and fire resistive walkways throughout the building.

Mixed

Combustible

In the first category are 9.98 percent of the buildings in the seventeen states. In the second category are 16.70 percent of the


PERCENT OF COMBUSTIBLE AND FIRE RESISTIVE BUILDINGS
76.7% OF BUILDINGS ARE ONE-STORY
18.0% OF BUILDINGS ARE TWO-STORY
5.3% OF BUILDINGS ARE THREE OR MORE STORIES
One-Story
Two-Story
Three or More Stories
DATA FROM 17 STATES ENROLLING 6,071,195 PUPILS
1 2 3 4
1. FIRE RESISTIVE
2. SEMI-FIRE RESISTIVE
3. MIXED
4. COMBUSTIBLE

buildings; in the third, 3.65 percent. In the "combustible" category are 69.67 percent.

When the buildings are cross-classified as being a one story, two story, and three or more story structure, it is found that 81.03 percent of the one-story buildings are combustible; 34.06 percent of the two-story buildings and 26.16 percent of the three or more story buildings are combustible.

In the survey the buildings are re-classified as being

Acceptable as to fire safety

One story buildings coming within this classification may be constructed of any type of suitable materials **provided adequate exit facilities are available** and **provided that "hot spots" like furnace rooms are sufficiently isolated.**

Two-story buildings provide acceptable pupil protection if they have fire resistive outside walls, corridors, and stairs, and have adequate exit facilities.

Buildings of three or more stories to be classified as acceptable should be fire resistive throughout except that wood may be used for floor coverings and trim.

Possibly acceptable as to fire safety

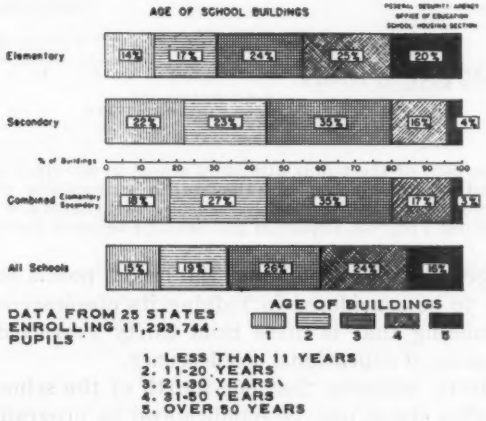
in this category were placed the two-story buildings pre-

viously classified as semi-fire resistive and mixed.

Not acceptable as to fire safety

In this category were placed all two-story buildings previously classified as combustible and all three or more story buildings not previously classified as fire resistive.

Under this system of classification it was found that sixty-eight percent of the elementary school pupils in the seventeen states were enrolled in buildings acceptable as to fire safety; sixty percent of the secondary pupils were enrolled in fire safe buildings. Fifteen percent each of the elementary and secondary school pupils were enrolled in buildings possibly acceptable as to fire safety.



Seventeen percent of the elementary school pupils and twenty-five percent of the secondary school pupils, who in sum accounted for twenty-one percent of the six million enrolled pupils, were enrolled in buildings not meeting the fire safety conditions as outlined in the report.

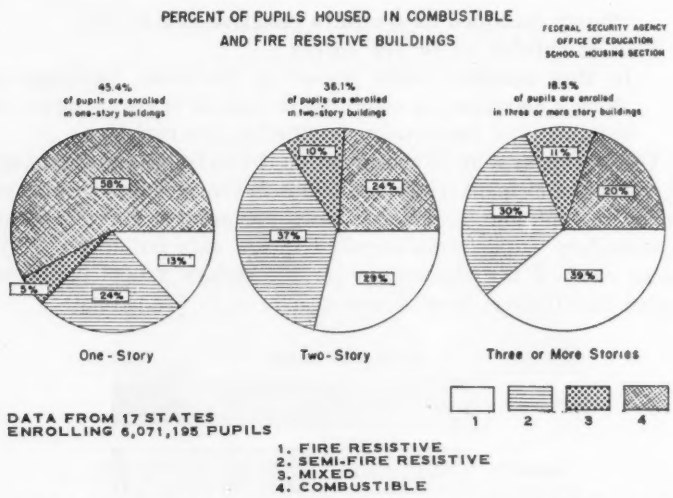
Two other factors which possibly affect the safety of pupils are included in the First Progress Report:

The age of the buildings inventoried

The number of pupils enrolled per classsroom.

Twenty-five states enrolling eleven and a quarter million pupils had completed the survey of existing facilities classified as to age.

Twenty-seven percent of the eleven and a quarter million pupils were enrolled in buildings more than thirty years old. Seven percent of the pupils were enrolled in buildings more than fifty years old.



Fifty-eight percent of the pupils attending school in one-story buildings in the states covered by this survey are housed in combustible structures, only thirteen percent attend in fire resistive schools. All charts are taken from the First Progress Report of the School Facilities Survey.

The age of a school building, the report points out, is not the only factor to be considered in judging its obsolescence. However, a school building that is more than thirty years old is probably reaching a state of educational obsolescence.

The survey indicates that one-fourth of the school children in the twenty-five states may be handicapped by program restrictions resulting from obsolescence.

In this obsolescence study of the School Facilities Survey the buildings were classified as

Elementary
Secondary
Combined.

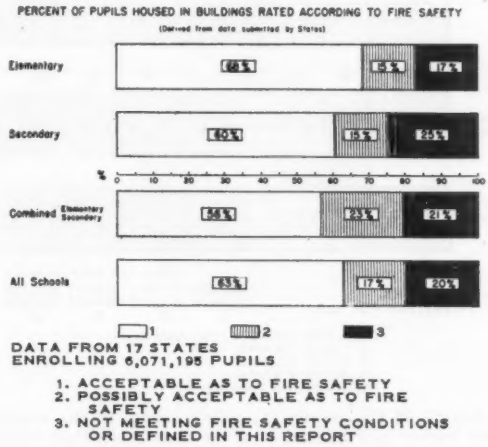
Twenty percent of the elementary school pupils and sixteen percent of each the secondary school and combined school pupils are enrolled in buildings less than eleven years old.

Nineteen percent of the elementary school pupils, twenty-one percent of the secondary school pupils, and twenty-seven percent of the pupils in combined buildings are enrolled in structures from eleven to twenty years old.

The largest group of pupils are enrolled in buildings which are between twenty-one and thirty years old; elementary twenty-nine

percent, secondary forty percent, combined thirty-eight percent.

Many states have recommended limiting class sizes, some states have established the maximum acceptable enrollment at thirty pupils.



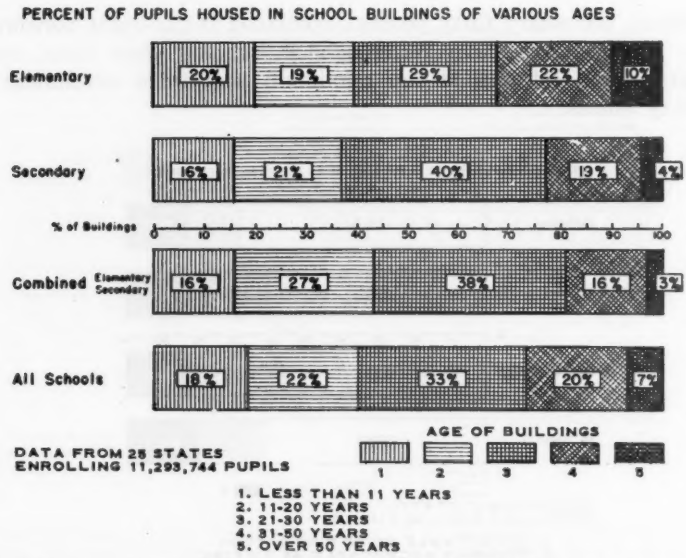
Buildings were rated by the state agencies as being satisfactory, fair, or unsatisfactory on such features as location, educational adequacy, structural stability, essential life and health protective features, fire safety and other pertinent factors. Forty percent of the buildings were reported by the twenty-five state authorities as being unsatisfactory. The classroom load was considered only for those structures which had been rated satisfactory or fair by the state authorities.

Forty-three percent of the eleven and a quarter million pupils enrolled in schools in the twenty-five states which have completed this phase of the inventory are enrolled where the classroom load exceeds thirty pupils.

Three percent of the pupils are enrolled where the classroom load exceeds fifty pupils.

The percentages do not take into account the extent of the overcrowding in unsatisfactory plants and in rented or other makeshift quarters.

A measure of overcrowding, other than the pupil load per classroom, might be the classification of schoolrooms by the number of square feet available per pupil. Again, the study was made only for satisfactory and fair structures.



More than one-fourth of the pupils attending school in the states covered by this phase of the survey are housed in structures more than thirty years old.

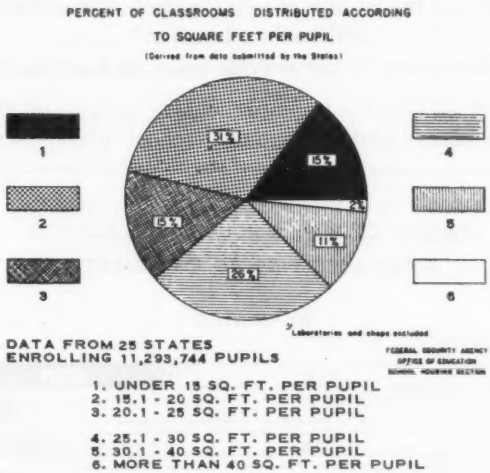
Classrooms were divided into six groups and the percent of the total number of classrooms was calculated for each group. According to the twenty-five state authorities, the findings were these:

Square feet per pupil	*Percent of classrooms*
0-15	14.81
16-20	31.40
21-25	15.09
26-30	25.92
31-40	11.15
More than 40	1.63

No national standards exist as to the number of square feet of classroom floor space per pupil. The National Council on Schoolhouse Construction, however, recommends at least thirty square feet per pupil for primary and intermediate grades. Secondary classroom space requirements vary with the type of instruction. Laboratories and shops were excluded from the findings above.

Eighty-sevent percent of the classrooms in the twenty-five states fail to provide the recommended minimum of thirty square feet of floor space per pupil. In almost half of the classrooms the

volume of space fails to meet the legal minimum requirements established for, say, office workers in the city of Chicago. That is, there is less than 200 cubic feet of space per pupil, allowing for a ten foot ceiling.


PERCENT OF CLASSROOMS DISTRIBUTED ACCORDING
TO SQUARE FEET PER PUPIL
(Derived from data submitted by the States)
1
2
3
4
5
6
DATA FROM 25 STATES
ENROLLING 11,293,744 PUPILS
1. UNDER 15 SQ. FT. PER PUPIL
2. 15.1 - 20 SQ. FT. PER PUPIL
3. 20.1 - 25 SQ. FT. PER PUPIL
4. 25.1 - 30 SQ. FT. PER PUPIL
5. 30.1 - 40 SQ. FT. PER PUPIL
6. MORE THAN 40 SQ. FT. PER PUPIL

These are the conditions in the "satisfactory" school buildings. The twenty-five participating states also reported the number of pupils attending school in

Rented quarters or other facilities outside of school buildings. There were 264,870.

School owned barracks buildings or similar structures not designated for school use. There were 137,274.

Makeshift quarters in buildings designed for permanent school use. There were 257,248.

Among the makeshift quarters enumerated were hallways, cloakrooms, storage rooms and corners of auditoriums which have been pressed into use as classrooms.

The First Progress Report of the School Facilities Survey covers only the inventory of twenty-five states. Additional reports are planned to cover the inventory for all of the participating states.

A second part of the survey will be a summarization of the current needs for additional facilities and an inventory of the state and local resources available for meeting these needs.

The First Progress Report may be purchased from the superintendent of document at the government printing office, Washington.

NATION'S 1951 SCHOOL-BUILDING STATUS AND NEEDS*

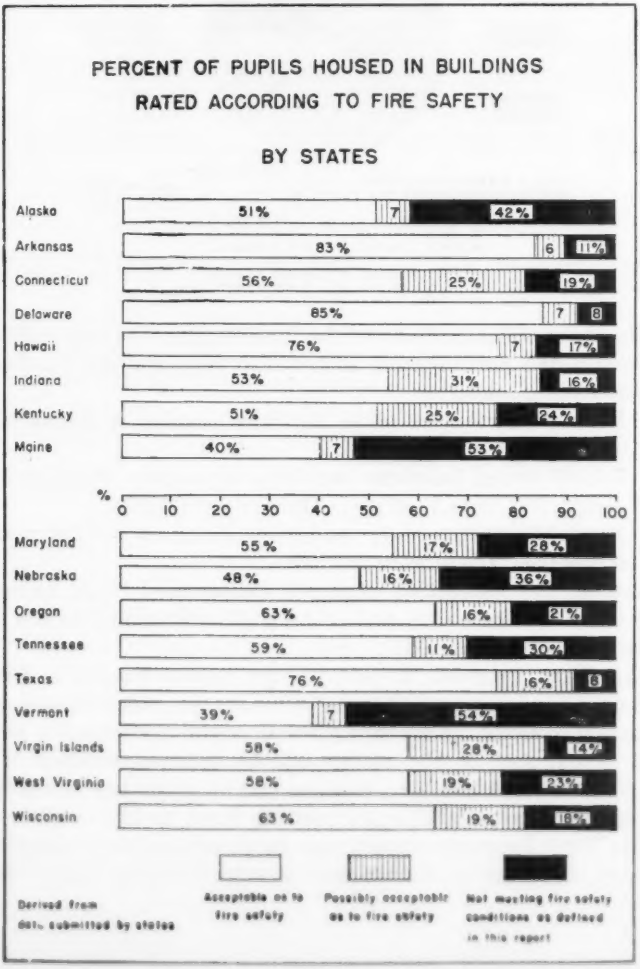
How old are the school buildings our children attend?

How many pupils attend school in buildings not meeting fire safety conditions?

What are the results of inadequate facilities for our children's education?

How many do not provide essential facilities?

A report of the first comprehensive survey of the Nation's public elementary and secondary school plant facilities ever

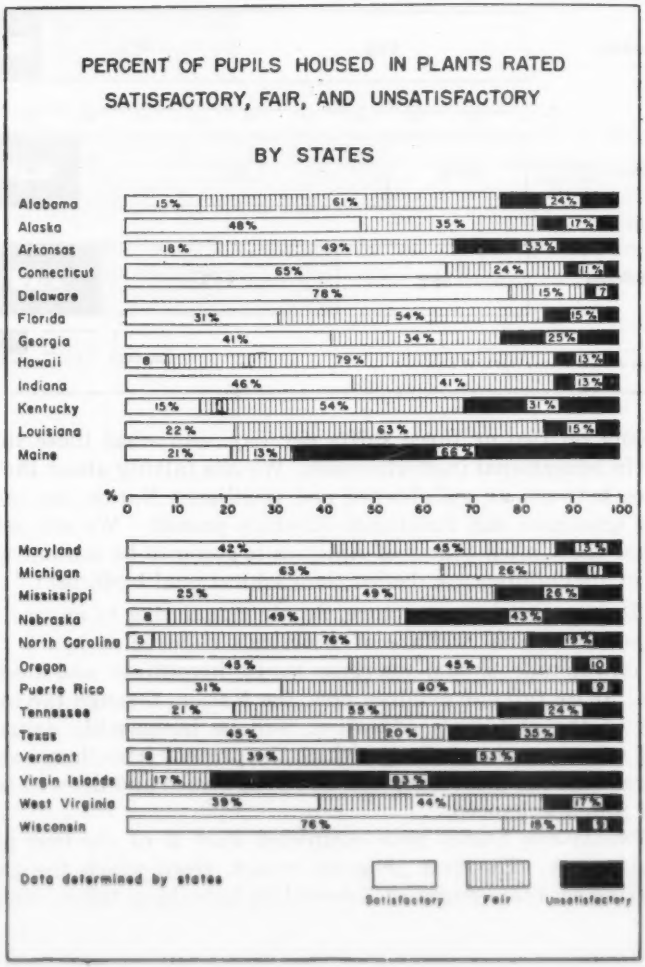

PERCENT OF PUPILS HOUSED IN BUILDINGS
RATED ACCORDING TO FIRE SAFETY
BY STATES
Alaska 51% 7 42%
Arkansas 83% 6 11%
Connecticut 56% 25% 19%
Delaware 85% 7 8
Hawaii 76% 7 17%
Indiana 53% 31% 16%
Kentucky 51% 25% 24%
Maine 40% 7 53%
% 0 10 20 30 40 50 60 70 80 90 100
Maryland 55% 17% 28%
Nebraska 48% 16% 36%
Oregon 63% 16% 21%
Tennessee 59% 11% 30%
Texas 76% 16% 8
Vermont 39% 7 54%
Virgin Islands 58% 28% 14%
West Virginia 58% 19% 23%
Wisconsin 63% 19% 18%
Derived from data submitted by states
Acceptable as to fire safety
Possibly acceptable as to fire safety
Not meeting fire safety conditions as defined in this report

attempted has just been submitted to the Congress by the Office of Education, Federal Security Agency.

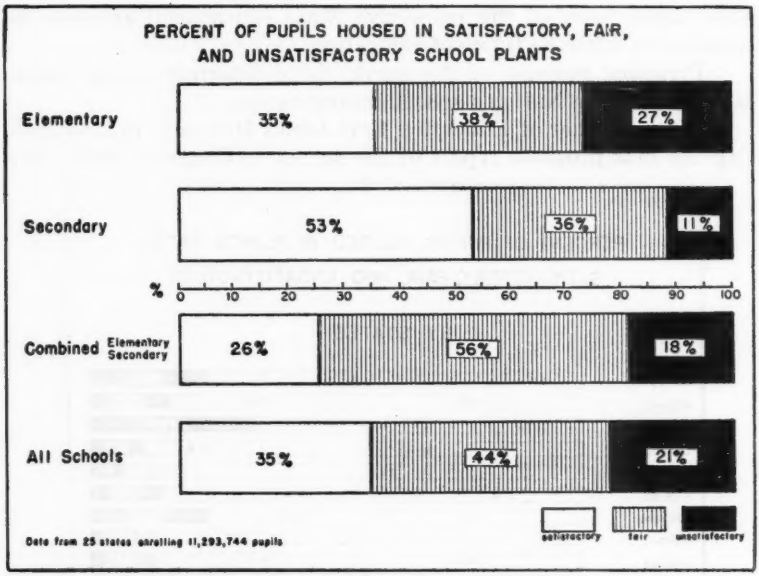
The Nation-wide school facilities survey, authorized by Public Law 815 of the Eighty-first Congress, is being made under immediate supervision of the respective State educational agencies in cooperation with the Office of Education.

Principal purpose of the survey is to determine steps necessary to meet the Nation's schoolhousing needs.

Commissioner of Education Earl James McGrath, in transmitting the first progress report of the survey to Congress, said, "We


PERCENT OF PUPILS HOUSED IN PLANTS RATED SATISFACTORY, FAIR, AND UNSATISFACTORY
BY STATES
Alabama 15% 61% 24%
Alaska 48% 35% 17%
Arkansas 18% 49% 33%
Connecticut 65% 24% 11%
Delaware 78% 15% 7
Florida 31% 54% 15%
Georgia 41% 34% 25%
Hawaii 8 79% 13%
Indiana 46% 41% 13%
Kentucky 15% 54% 31%
Louisiana 22% 63% 15%
Maine 21% 13% 66%
% 0 10 20 30 40 50 60 70 80 90 100
Maryland 42% 45% 13%
Michigan 63% 26% 11
Mississippi 25% 49% 26%
Nebraska 8 49% 43%
North Carolina 5 76% 19%
Oregon 45% 45% 10
Puerto Rico 31% 60% 9
Tennessee 21% 55% 24%
Texas 45% 20% 35%
Vermont 8 39% 53%
Virgin Islands 17% 83%
West Virginia 39% 44% 17%
Wisconsin 76% 15% 9
Data determined by states
Satisfactory
Fair
Unsatisfactory

are talking not merely about dollars, but about what those dollars mean to the immediate and the long-run future of this Nation. We are talking about firetraps, dilapidation, overcrowding, part-time



schooling on two or three shifts per day, and what these things mean in educational ineffectiveness. We are talking about the difference between an enlightened and intelligent Nation and one in which ignorance and functional illiteracy prevail. We are asking whether the United States of America is going to be content while some of its children are denied their educational birthright."

"It is a disquieting picture, deeply disquieting to anyone who has the educational welfare of America's children at heart. This very disquietude should energize us in immediate and decisive action. If we fail our children now, the Nation, through the inadequacy of the children's education, will be irreparably damaged. But if we rise to the challenge which the present schoolhouse shortage presents, our democracy will be strengthened and the well-being of our people enhanced."

Twenty-five States have completed Part A of the first phase of the survey. The first progress report, from which the charts appearing on these pages of *School Life* have been taken, includes

only the inventory portion of the first phase of the School Facilities Survey in these 25 States.

Ray L. Hamon, Chief of the School Housing Section, Office of Education, is serving as survey coordinator at the Federal level.

Copies of the "First Progress Report of the School Facilities Survey" are available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. The single copy price is 40 cents. Mats of four of the charts which appear in the Report have been prepared for publication purposes, and may be obtained without charge from the Office of Education, Federal Security Agency.

SCOPE OF REPORT

The 25 States whose survey reports are included in this progress report represent 11,293,744, or 44.06 percent of the 25,629,698 public-school pupils enolled in the Continental United States and in the territories included in this survey during the school year 1949-50 as reported to the Research and Statistical Service Section of the Office of Education by the several States.

* From School Life.

* * * * *

Abram D. Burr, M.D.—Word has been received of the decease of Abram D. Burr, M.D., on July 4, 1952. He had been School physician in Gouverneur, N. Y., for sixteen years.

THE HOMEROOM AS A MEDIUM FOR HEALTH GUIDANCE

By JAMES H. HUMPHREY

School of Education, Boston University, Boston Massachusetts

Major health problems in the world today very definitely point up the need for organized health programs in the public schools. Moreover, the place and importance of health should be so well known and appreciated that no justification of health guidance as one of the school's primary concern should be necessary.

Although it would perhaps be difficult to find a school where some form of health guidance was not in evidence, it must be conceded that in most instances health guidance is of an incidental nature and few schools at the present time have organized health guidance programs. At this time it would perhaps be a premature generalization to say that there is a trend toward organized health guidance programs. However, it would seem safe to state that some inroads are being made on this relatively new movement.

In the early stages of any new development it is likely that many misunderstandings are apt to occur and this could be true in the case of health puidance. Criticism is likely to come from many persons not thoroughly conversant with the field; therefore it seems necessary that those responsible for the health guidance program should investigate the many avenues open to this particular guidance approach. With the above in mind it will be the purpose here to explore some of the possibilities of the homeroom as a medium for health guidance in the public schools.

General Guidance

In describing the homeroom in its earliest form Fretwell[1] has said:

> "It was known frequently as the Session, or Record or Book Room and as such was usually composed of one teacher and twenty-five to forty or fifty pupils. As high schools increased rapidly in size, it was in the Record Room, in many cases that practically all of the school's administrative routine was carried on. It was here that attendance was recorded, schedules were made, details of enrollment taken care of, reports distributed, and many problems of discipline solved. With the increasing size of school enrollments and with the development of the idea of pupil guidance, the Session, Record, or Book Room took on various advisory functions, and as such has come to be known at the Home Room."

1. E. K. Fretwell, *Extra-Curricular Activities in the Secondary Schools* Boston: Houghton-Mifflin 1931. p. 20

Over two decades ago the National Committee on Guidance concluded[2] that the homeroom teacher functions in all phases of guidance. They reported as follows:

> "She comes to know each pupil in the room more intimately than any other teacher. She has the opportunity to know the pupil in all his relationships—his studies; his difficulties with other teachers; his problems of discipline; his home conditions and environment; his associates in school and out; and his attitudes, interests, and abilities. Therefore, whether the school be large or small, it is the homeroom teacher with whom the foundations for guidance must be laid."

According to Dunsmoor[3], there has been a great deal of disagreement as to the extent to which the homeroom can logically be used for guidance purposes. He mentions three distinct positions which have been taken on the problem:

1. The homeroom should do most of the guidance of the school.
2. The homeroom should do but little of the guidance of the school.
3. The homeroom should be the chief agency for some kinds of guidance, but should not attempt other kinds.

Sach[4] made a comparative evaluation study of two programs of group guidance, one operating under a homeroom, and one under a guidance-teacher plan of organization. She found that homeroom groups tended to emphasize areas classifiable under personal and social adjustment, while group guidance taught by teacher-counselors gave relatively greater emphasis to areas concerned with life planning. Homeroom teachers with their lower pupil-teacher ratio, possessed information about pupils and had established better relationships with them, than had teacher-counselors.

Wagner's[5] survey of practices in 125 secondary schools of the North Central Association would corroborate the above data since her survey indicated that homerooms were contributing effectively to desirable pupil-teacher relationships.

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2. Report of the Committee on Guidance, "*Guidance in Secondary Schools*," National Association of Secondary School Principals, Bulletin No. 19, January 1928, p. 20

3. C. C. Dunsmoor, "*Effective Homeroom Guidance*," Education, Vol. 57, June 1937, p. 605

4. Georgia M. Sachs, "*Evaluation of Group Guidance Work in Secondary Schools*," Los Angeles, California, University of Southern California Press, 1945

5. Josephine E. Wagner, "*Factors Conducive to the Effective Functioning of the Homeroom Organization*," National Association of Secondary School Principals, Bulletin No. 30, January 1946, p. 88

Health Guidance

With the above information serving to some extent as an indication of the possibilities of guidance through the homeroom, it might be well to investigate some of the possibilities of the specific area of health guidance through this particular medium.

Grout[6] suggests that the homeroom may make various contributions to the school health program in terms of individual and group guidance. She states that:

> "Individual health guidance is one of the most important functions of the homeroom. The homeroom teacher is in a better position to know about the pupil's health problems than any other person in the school. She meets the pupil daily, she keeps the pupil's attendance and academic records, and sometimes she also keeps the health and personal records."

Although the health welfare of pupils should be a responsibility of all teachers, perhaps the homeroom teacher may be in a more strategic position as far as health guidance is concerned. Pupil records in the hands of the homeroom teacher can be studied with health factors in mind. For example, if a pupil is frequently absent from school, the health factor should be investigated thoroughly.

Personal counseling may be used to great advantage as a means of individual health guidance in the homeroom since the homeroom teacher may have a better opportunity to obtain the confidence of a pupil. Consequently, many of the health problems revealed through study of records can be handled in personal interviews between teacher and pupil. However, in the personal interview with the pupil it is of paramount importance that the teacher keep in mind that it is her duty to detect and refer rather than to diagnose and prescribe.

In regard to group health guidance, the health phase of vocational guidance might well be an important function of the homeroom. The pupils could perhaps become familiar with personal health requirements of the various occupations as well as the health hazards which exist in the different types of occupations.

Through the homeroom, pupils may learn of the health services available to them in the school and in addition they might be made aware of the services offered by the official and non-official community health agencies.

McKown[7], in appraising the guidance function of the home-

6. Ruth E. Grout, *"Homeroom Activities in the Field of Health,"* Secondary Education, Vol. 13, Sepetember 1947, p. 11

7. H. C. McKown, *Homeroom Guidance*, New York, McGraw-Hill, 1946, p. 388

room gives the following three advantages with regard to its utilization in health guidance:

"1. The consideration of timeliness; the activities of Health Week, Safety Week, etc., can be more easily scheduled in the homeroom than in the regularly organized courses in the curriculum.

2. Campaigns and drives as well as competitions between groups and schools may originate easily and naturally in the homeroom situation.

3. Because of the more or less informal presentation of the homeroom, most of the members of the group may participate freely."

Although all of the above advantages listed by McKown contain merit, it would appear to the writer that the last mentioned one is of greatest significance in utilizing the homeroom as a health guidance medium. In as much as the homeroom represents more informality than the ordinary classroom, the homeroom teacher should be in a position to take full advantage of the group guidance case conference method. Since she will come in contact with the pupils more often than other teachers it will be possible for her to detect certain attitudes in the class. When she identifies on attitude that has implications for health guidance, she may then frame a case—an actual life situation within the experience of the group. She can create a permissive atmosphere and attempt to get all view points of all of the pupils into the open for discussion.

Along with any of the advantages which might be mentioned, naturally certain disadvantages may be cited in using the homeroom for the purpose of health guidance. Chief among these perhaps might be that the differences in knowledge, interest, and abilities of the homeroom teachers will preclude the possibility of a completely adequate job. Turkenkopf[8] would refute this by bringing to attention the fact that:

"She is not expected to be a diagnostician, nor to delve beyond her lay training, but with warm and sincere interest in each student she can pave the way for a good relationship so that when she has reached her own limitations in her capacity as an adviser, she can call on the specialists to take up where she left off."

Although it has not been the purpose here to extol the rectitude of the homeroom as a medium for health guidance, there never-

8. Florence H. Turkenkopf, *"Role of the Homeroom Teacher in a Guidance Program,"* High Points, Vol. 31, April 1949, p. 63

theless seems to be sufficient reason to believe that the homeroom should be recognized as a possibility for pioneering in this area. In the beginning stages of the development of an organized health guidance program the homeroom certainly should not be considered a facility for exhausting all of the health guidance opportunities. However, it might well be considered as a medium through which certain contributions may be made in this area.

* * * * *

Deficiencies in Knowledge of BCG Vaccine,—BCG vaccine cannot replace other antituberculosis measures that have proved successful in this country. It may confer partial immunity on those inoculated, but the degree of immunity attained is far below that attained against diphtheria, tetanus, or smallpox following the use of the appropriate toxoid or vaccine. Dr. Robert Anderson, chief of the tuberculosis division of the U. S. Public Health Service, has stated that BCG vaccine cannot be considered an absolute preventive against tuberculosis, and that efforts are still being made "to find more stable and suitable immunizing agents." The principal disadvantages connected with the use of BCG vaccine at present are as follows: 1. No method has yet been developed for stabilizing its potency. 2. The exact degree of immunity conferred and its duration are unknown. 3. No agreement has yet been reached in regard to correct dosage or administration. Variations in the effect of the vaccine on different racial groups have also been noted. Acceptance of BCG vaccination as a general public health measure is not warranted; until further information on disputed points is available, its use should be continued on an experimental basis only. *Journ. A.M.A.*, Sept. 20, 1952, p. 245. *From Diseases of the Chest*, Chicago, May, 1952.

* * * * *

Announcement,—The American Trudeau Society, Medical Section of the National Tuberculosis Association, invites the submission of abstracts of scientific papers for presentation at its next annual meeting in Los Angeles, California, May 18 to 22, 1953, at the Hotel Statler.

Full information can be obtained by writing to the Chairman of the Medical Sessions Committee, American Trudeau Society, 1790 Broadway, New York 19, N. Y.

* * * * *

Health Material,—A new Health publication "Health Materials and Resources for Oregon Teachers," has ben issued by the Oregon State Department of Education.

CARDIAC SURVEY IN AN ELEMENTARY PUBLIC SCHOOL[1]

CHARLES L. OUTLAND, M.D., F.A.P.H.A.,
Medical Director, Public Schools, Richmond, Virginia[2]

In order to obtain data on the normal electrocardiogram in children, arrangements were made to take 12-lead electrocardiograms on all students in an elementary school in Richmond. So that abnormal subjects could be excluded from the analysis, each child was given a physical examination with particular attention to the cardio vascular system. This was carried out by a team of physicians from the Children's Cardiac Clinic of the Medical College of Virginia.[3] The primary purpose of this project was the electrocardiographic data on normal children which will be reported elsewhere. Nevertheless, it is thought that the cardiovascular findings in this group of children might be of sufficient interest to report as a separate presentation at this time.

The school selected for the study was an elementary school in the Richmond Public Schools system serving a neighborhood of families chiefly of the lower or middle income economic status. There were 671 white children in this school ranging in age from five to thirteen. There were 339 males and 332 females. (See chart) All were white.

In this survey only one instance of definite organic heart disease was found. This was a case of rheumatic heart disease with mitral insufficiency in a 10-year-old girl who gave a questionable history of previous rheumatic fever.

There were other instances of deviations from the normal which were considered to be either physiologic in origin or whose significance cannot be assessed at this time and must await further observations. These will be commented upon briefly.

History of Rheumatic Fever—Each child was asked whether or not he or she had ever had rheumatic fever. This obviously was not an adequate survey of the incidence since the answers cannot be considered reliable from such a source. However, for whatever value can be attached to the replies, seven children gave definite histories of rheumatic fever and three additional children with questionable histories. Only one of this group had evidence of

1. Read before American School Health Association, Cleveland, Ohio, October 20, 1952.

2. Lecturer in Public Health, Medical College of Va.; Medical Director of City Schools.

3. Rene R. Porter, M.D., Howard McCue, Jr., M.D., Carolyn McCue, M.D.

residual heart damage. This was the child with mitral insufficiency who gave a history suggesting possible rheumatic fever.

Arrhythmias—Sinus arrhythmia was a frequent finding as would be expected in a group of children. In addition, there were seven subjects exhibiting premature beats (extrasystoles). One of these was noted on physical examination only and its origin is unknown. In six instances the premature beats were noted on the electrocardiogram and were ventricular in origin. The frequency of these extrasystoles varied. In four cases they occurred only occasionally. In two cases they were frequent in occurrence, producing a bigeminy (every normal beat followed by an extrasystole) in one case. This latter is most unusual as a physiologic phenomena, but we consider it simply an evidence of increased cardiac irritability in the absence of other evidence of disease. The remaining instances of premature beats were likewise thought to be benign in nature.

Cardiac Murmurs—The evaluation of cardiac murmurs is sometimes quite difficult and is subject to some personal subjective interpretation. We attempted to determine the significance of murmurs by classifying them as "organic" or "physiologic". We consider the organic murmurs to represent actual or relative structural deformity in the heart or vascular system and therefore, pathognomic of cardiovascular disease. Physiologic murmurs are those auscultatory phenomena which are produced by a variety of benign cardiac and extra-cardiac factors. Their exact mechanism of production still remains obscure, but they are considered to be due to such physiologic variations as the anatomic position of the heart in the chest, the size, shape, thickness and inherent resonance of the chest wall, the vigor of cardiac action, and the like. The identity of these murmurs is important since they have no significance and do not indicate intrinsic heart disease. This differentiation arises only in the case of systolic murmurs, since all diastolic murmurs can be considered "organic". The differentiation of the systolic murmur is made on the basis of the particular characteristics of the murmur. Organic murmurs tend to be loud in intensity, high-pitched, prolonged, and rough, while physiologic murmurs are of less intensity, low-pitched, short and blowing. It is our feeling that the pitch and duration of the murmur is of more importance in differentiation than intensity or quality. We are not greatly influenced by the effect of exercise on the murmur. In our experience, one cannot be sure of the significance of systolic murmurs in all instances. Occasionally a murmur may have some of the char-

acteristics of both an organic and a physiologic murmur. Under these circumstances, we must depend upon other accessory findings or lacking definite information there, we have to reserve final decision and defer the diagnosis.

In this group of cases there was found only one instance of an unquestioned organic murmur. This was an apical systolic murmur and was interpreted as indicating mitral insufficiency. In four subjects in this series, somewhat loud, harsh, prolonged, pulmonary systolic murmurs were heard, which suggested an organic lesion, such as some congenital defect. However, other studies such as the electrocardiagram and heart size, were negative, suggesting that these were physiologic sounds in spite of their characteristics. These were considered questionable murmurs and final opinion deferred until later follow-up.

Definite physiologic murmurs were heard in 79 cases as follows:

Precordial twang	34
Pulmonary systolic	25
Apical systolic	17
Aortic systolic	2
Apical and aortic systolic	1
	79

"Precordial twang" is the term which was first used by Harris to indicate a particular heart sound heard rather commonly in children. It is a low-pitched, short, somewhat vibratory sound heard in mid-systole. It is heard all over the precordium but its maximum intensity is in the mid-precordium being of less intensity at the pulmonic area and at the apex. This is considered to be of physiologic origin, the exact nature of which is obscure. In our experience, it is the physiologic sound most commonly misinterpreted as indicating valvular disease.

Physiologic pulmonary systolic murmurs are short, low-pitched, blowing murmurs which have their maximum intensity over the pulmonic area. They are not as short and do not have the vibratory quality of the precordial twang.

The remaining physiologic murmurs were less common, and were murmurs with similar characteristics as the pulmonic murmurs, but with maximum intensity at the areas noted.

Blood Pressure—There was a wide range of blood pressure. There does not appear to be a significant difference between males and females. There tends to be an increase in blood pressure, at

least the systolic level, with increasing age, but this is not striking.

The blood pressure in this group of children is shown in the following slides. These are arranged in age groups with separate values for males and females. The length of the columns represent the range and the line indicates the average for each category.

We cannot assess the full significance of these data. Blood pressure readings are difficult enough to evaluate in adults, in whom we supposedly have normal standards. When one considers the circumstances under which those blood pressures were taken and the probably emotional state of the child at the time, the results obtained can only be relative and speculative. No figures are available on the range of blood pressure in normal children, so it is impossible to say if any of these are abnormal. It is of interest that pressures were recorded as high as 150 systolic and 90 diastolic. In ten instances, the blood pressure was greater than 130 systolic or 80 diastolic, or both. Whether these findings are of any significance will await further study.

Electrocardiographic Findings—The primary purpose of this project was to obtain for analysis the electrocardiograms on a large group of apparently normal children. The detailed study of these tracings for the range of the normal is to be reported elsewhere, but certain interesting variations were noted. As noted previously, there were six instances of ventricular premature beats (extrasystoles). The heart rate apparently had nothing to do with the occurence of these beats.

A P-R interval of as long as 0.26 sec. was found in one instance, a ten year old female whose rate was 85. This is somewhat above the accepted upper normal limit for adults, but there was nothing else to suggest rheumatic fever and probably is a normal physiologic variation similar to what has been found in adults.

One instance in which the QRS interval measured 0.10 secs. This value is considered abnormal according to adult standards but again is probably physiologic. There was one instance of nodal rhythm ("coronary sinus rhythm"), with inverted P waves in leads II and III, a P-R interval 0.12 and a rate of 100. This was considered to be benign.

COMMENT

1. This is a brief preliminary report. Deviations found will have to await further study for final evaluation.
2. A study of 671 children was made in a school to see what might be found in supposedly normal children ages 5-12.
3. No definite conclusions were arrived at.
4. We hope similar studies may be made and that there may come out of these some information which might be considered normal for this age child.

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EDITORIAL

Unsafe Schools,—The leading articles in this *Journal* deal with the great number of aged, derepit, unsafe and insanitary school buildings.

We do not know the date of construction of all these buildings, but we do know that some of them were built during the early 1860's. They are now eighty or more years old. Since the era of modern school house construction did not begin until after 1900, it is probable that most of these patriarchs are in the unsafe and unhealthful group.

We have left these items of child health and safety to careless and incompetent School Committees, Boards of Education, and Superintendents, and the enforcement of safety and health laws to timid, careless, or ignorant State Departments.

In many areas there will be little real effort toward improvement until the people most concerned—the parents of the children —use the power of the vote to compel recalcitrant School Boards and school officers to do their plain duty. Parent Teacher Associations and other organized groups should give more attention to these menaces, and use every possible pressure to bring about corrections.

Visit school buildings:—not only your own, but those that are models of up-to-date school house construction. Unless you see

new modern buildings, you have no standards by which to judge the ones your own children attend.

Know the health and safety standards and regulations, and the channels of appeal to higher authority if local appeal is ineffective.

Get rid of the old rattle traps. It will cost more to remodel and repair a school building that was in use when Grant and Lee met at Appomatox, than it will to build a modern one on an adequate healthful site.

Don't dodge your responsibility by saying "we do not know." There are plenty of sources of information, and numerus people who will be glad to help you, such as:

U. S. Office of Education, Washington 25, D.C.
State University Schools of Education.
State Departments of Education.
American Public Health Association.
State Education Associations and others.

Now is the Time!,—The terrible Collinswood school fire catastrophy in Cleveland and the similar one in Massachusetts nearly a half century ago started our modern school building construction program. Must we wait for similar horrors to force school authorities—and parents—to pull their heads from under the basket of complacency long enough to modernize before it is too late?

"Of all sad words of tongue or pen,
The saddest are these, 'it might have been'."—*CHK.*

* * * * *

Manuscripts,—In general my reaction concerning manuscripts is as follows:

1. Authors show up very definitely the failures in English Composition in our "progressive (?) education" public schools for the last twenty or thirty years. They use few commas, therefore their meanings often are not clear. Most of them never heard of a semi-colon, and none of a colon.

2. Long preambles are common. These mean little, often have slight bearing on the real content of the paper, and waste paper, time, and the reader's patience.

If they present statistical material, they duplicate written statements, usually adequate, with long minute tables dealing with so few units that they have little statistical value. Many use three or four thousand words to say what could be said better in two thousand. Most of these are sent back for condensation.

"No member of the congregation is saved after the first twenty minutes."—*CHK.*

CHRISTMAS SEALS HELP MAKE TB CURES POSSIBLE

New methods of treatment make it more important than ever to find the 150,000 "unknown" cases of tuberculosis—people who are infecting others . . . and losing their own health.

These "unknowns" must be found and spread of infection controlled—by more chest X-ray, educational, and research programs. These are just some of the activities encouraged and supported by your Christmas Seal dollars.

Remember, no one can be "cured" until treated . . . and no one can be treated until found. So, continue the winning fight against tuberculosis. Send in your contribution today.

BUY CHRISTMAS SEALS

Because of the importance of this message, space contributed by

American School Health Association

ABSTRACTS AND NOTES

School Health Service In England And The United States—A Comparison

Charles C. Wilson, M.D., F.A.P.H.A.,
Professor of Education and Public Health, Yale University,
New Haven, Conn.
Abstracted by C. H. Maxwell, M.D.

Dr. Wilson spent two months in England and Scotland studying the school health program and comparing it to the programs in the United States.

In the United States the school program is governed by the state laws which vary in the forty-eight states, covering 3,000,000 square miles and over 150,000,000 people. In England there is a uniform law for the whole country covering over 93,000 square miles and 50,000,000 people.

The English law effective in 1944 requires the local education authority to appoint a school medical officer. The minister of education and the minister of health recommend that the local medical officer of health be appointed the school medical officer, and this has been done, except in three or four local areas. In the United States, the administration may be either under the department of health or the department of education, depending on the state and local laws. Coordination between the two services is obtained by local health councils in this country, and in England by the local medical officer who is also the school physician.

The routine medical examinations in England as required by regulation are at the time of entrance to school, in the last year of the primary school about the age of 10 years, and in the last year of secondary school at the ages of 14 to 15. This differs little from the recommended practice in many of the states in the United States. Both countries recognize the importance of referred examinations at the suggestion of the teacher or the parent. Parental attendance is advocated in both countries, and in England over 80% of the younger children are accompanied by the parent.

Measuring height, weight, testing vision and hearing acuity are carried out in England by nurses, whereas, in the United States these may be carried out either by the teacher or the nurse. It was the impression of Dr. Wilson that the teacher in the United States assumes a more important role in health service than does the teacher in England.

The health records in England are uniform for the whole country, whereas, in the United States they are more likely to be uniform only within the individual states.

The physical examinations in England are done entirely by the school medical officer, whereas, in the United States many of them are done by the private physician engaged by the parent.

Treatment for children needing care in England may be done by the family physician or through treatment centers under the board of health which supports school clinics. In the United States care is provided by the private physician engaged by the parent or through public clinics.

The central program for the school children in England has been curtailed since the national health service act has made private practice more remunerative than work in school clinics. In the United States many dentists apply sodium fluoride solutions to the teeth of children to prevent dental caries. Some communities fluoridate the water supply. There is no mention of this in the report on the English system.

In England there is close relationship between school health service and education, since the school medical officer is responsible for identifying pupils who need special education. In the United States special education is frequently organized into a separate department with psychologists, physiotherapists, guidance personnel working independently from the medical service.

* * * * *

The Educational Values of College Physical Education, Including Intercollegiate Athletics and Their Preservation *A. W. Marsh, The Educational* Forum XVI: 409-419, May, 1952. Abstracted by C. H. Maxwell, M.D.

The author presents a very good summary of college programs from 1859 (when Amherst College built a gymnasium and hired a physician to supervise the "physical exercise" program for the college) to the present. The values are physical, psychological, social, and moral and ethical. The social and moral values are best obtained thru competitive sports. In the field of intercollegiate sports is "the greatest potentiality for bad as well as good education. In this field only 20 to 50% at most, of the best trained students participate, but three quarters of the time, money and attention is devoted to this part of the program."

Intercollegiate sports, starting as student-controlled invitational games, have now become an end in themselves with professional coaches, paid players and alumni stimulation and interference, but little college control. "In some areas football games bear about the same relation to education as bull fighting does to farming."

In an attempt to control some of the evils of highly competitive intercollegiate sports, "the National Collegiate Athletic Association discovered last year at the annual meeting that two-thirds of the colleges would not support the enforcement of its regulations."

Efforts to "de-emphasize the exaggerated position of" intercollegiate sports include:

1. Recommendations of the National Collegiate Athletic Association regarding entrance requirements, progression towards a degree, scholarships, and out of season practice.

2. Regional conference regulations, even more stringent (the Eastern College Athletic Association, the Ohio Conference, The Little Three, the Ivy League).

3. American Council on Educational Report recommending elimination of bowl games, athletic scholarships, extra seasonal practice, freshmen on varsity teams. The report further recommends that the athletic funds should be handled by the University and that all athletes should make regular progress toward a degree.

4. Joint Committee of the American Association of Health, Physical Education and Recreation, the National Collegiate Athletic Association, and the College of Physical Education Association recommendations on controls of sports sent to all college Presidents.

* * * * *

Influence of TV Crime Programs on Children's Health,—Ever since the number of television sets in the United States zoomed from 10,000 in 1945 to 17,000,000 in 1952, the cumlative effect of television crime-and-horror programs on the health to American children has become a source of mounting concern to parents, teachers, and the medical profession. That this medium of mass communication exerts a potent, time-consuming influence on the younger generation is indicated by surveys, which show that children 5 and 6 years old are among the most constant viewers, often watching television for four or more hours a day. Many pupils in the 7 to 17 year age group average 3 hours daily, while some watch television 27 hours a week, almost as much time as they spend in their school classes[1].

The caliber of crime programs seen by television audiences is the subject of comment by the editor of *TV Magazine*, who supervised a study of crime programs televised by Los Angeles stations. During the week May 24-30, 1952, six monitors tabulated 852 major crimes, in addition to innumerable saloon brawls, sluggings, assaults, and other "minor" acts of violence. Their findings also included 167 murders, numerous robberies, jailbreaks, murder

conspiracies, false murder charges, attempted lynchings, dynamitings, and an attempted rape in a crime Western for children. Seventy-eight per cent of the crime deluge was presented on programs for children, with 85% of the programs televised before 9 p.m. The over-all impression gained by the monitors from the majority of television programs for children was that life is cheap; death, suffering, and brutality are subjects of callous indifference; and that judges, lawyers, and law officers are dishonest, incompetent, and stupid.

In terms of creating visual, acoustic, and psychological impressions on children, the portrayal of crime on radio and in the movies differs little from that enacted on television, since the dramatization of crime and horror in all three mediums of communication is distilled from identical ingredients. Unfortunately, astonishingly little research has been done on the medical and psychological impact of television on children. Many questions require answering, immediately and continuously, and would aid the orderly growth of television. Although Preston's study[2] of the reaction of 120 boys and 80 girls, aged 6 to 16, to movie horrors and radio crimes was reported in a pre-television period a number of years ago, the findings apparently apply equally well to television. She found the effects of habitual exposure to vary in this group, as expressed by its general health, sleeping and eating habits, fears, and nervousness. A total of 116 of 153 children habitually exposed to these mediums (76%) evinced increased nervousness, compared to its presence in 19 to 47 not habitually exposed (40%). Sleeping disturbances occurred in 130 of the 153 (85%), and in only 9 of the 47 in the control group (19%). Fears were increased fivefold in 144 in the first group (94%), as compared to 8 of the second group (17%). Seventy-eight of group 1 (51%) were found to be nail-biters, whereas 11 of group 2 (23%) engaged in nail-biting. In group 1, 85% always listened to the radio before bedtime, continuing to think of what had been heard while lying in bed. Crime, horror, and especially fear of kidnapping were uppermost in the minds of these children. Up to the age of 12, common reactions included retiring to the mother's bed for comfort and reassurance, screaming, pulling bed covers over the head, burying the head under the pillow, or diving under the covers, there to spend an uneasy night plagued by vivid recollections.

Preston points out that terrifying crime scenes frequently produce adverse effects on the organs of the body, as reflected in diminished food intake and consequent inability to gain

weight, troublesome dreams, restless sleep, and scholastic difficulties at school. Such unfavorable effects as lack of appetite, increased irritability, and malaise were observed in many children. As early as the seventh year it was noted that habitual exposure of young children to crime-and-horror programs often produced a callousness to the suffering of others and an atrophy of sympathy and compassion toward those in distress. Whenever possible, treatment consisted of eliminating or markedly restricting the exposure to crime-and-horror programs and the substitution of other, more healthful activities.

In all fairness, most physicians will agree that television, the movies, and radio are not harmful in themselves. All three mediums of mass communication, it is true, have often presented outstanding educational and entertainment programs. Yet the manner in which crime in these mediums is brought before the eyes and ears of American children indicates a complete disregard for mental, physical, and social consequences. For its own self interest, the television industry would do well to acknowledge the adverse medical and psychological implications found in many crime-and-horror programs. It should foster research on the impact of television on mind and body, and should make a sustained effort to avoid programming shows potentially dangerous to the health of the nation's children. Indeed, the television industry would be well advised to accomplish this voluntarily and as rapidly as possible in order to neutralize the growing hue and cry for governmental regulation and its attendant evils of censorship. There is more to the problem than the proposal made by one Congressman, who replied to the demand of an irate mother that he do something about television, by declaring "Did you ever think of turning the damned thing off?" *Editorial, Journ. A.M.A.*, Sept. 6, 1952, p. 37.

1. Witty, P. and Bricker, H.: *Your Child and Radio, TV, Comics and Movies*, Chicago, Science Research Associates, Inc., 1952.
2. Preston, M. I.: *Children's Reactions to Movie Horrors and Radio Crime*, J. Pediat 19:147 (Aug.) 1941.

* * * * *

Prevention of Tuberculosis in Schools.—A motion, addressed in 1952 to the Swedish Parliament, draws attention to an anomalous state of affairs with regard to the prevention of infection of schoolchildren by their teachers. The inmates in "day-homes" are carefully shielded by the law in this respect. Anyone employed in such institutions, even when the employment is of a temporary character, must be able to present a certificate that his or her lungs have been radiologically examined. Such workers are also kept

under continuous supervision with the possibility of tuberculosis always in mind. A much less satisfactory state of affairs exists with the possibility of tuberculosis always in mind. A much less satisfactory state of affairs exists with regard to older children attending school. School medical officers are expected to take the necessary measurers for preventing infectuous diseases among teachers and other school personnel, and schoolchildren are kept under constant medical supervision throughout their scholastic careers; but legislation does not provide for the systematic medical control of the school staff by radiological examinations.

Between 1944 and 1946 as many as 65 cases of tuberculosis occurred among schoolteachers. In 1943 a manual training teacher infected eight boys between the ages of 12 and 14, and in 1945 a substitute teacher in less than three months infected another teacher and 16 scholars. After giving further evidence of school infections, the authors of this motion recommended that throughout their careers teachers should be obliged to undergo periodic radiological examinations at least every other year and preferably every year, with even more frequent examinations when special conditions call for them. *Journ. A.M.A.*, Aug. 23, 1952, p. 1593.

* * * * *

Cot in Hall Serves as School Clinic, PTA Complains,—A cot in the corner of a hall to accommodate children taken ill is the makeshift "clinic" of School 36, located at 10 Days Park.

Because of this, and a long list of other complaints, such as an absence of a gymnasium, auditorium and lunchroom, the Parent-Teachers Association of the school has sent letters stressing the need for a new school to Mayor Mruk, members of the Board of Education and the Common Council.

The letters, written by Mrs. Anthony P. Cumbo, president, and Mrs. Robert Krebs, secretary of the PTA, who both have children in the fifth grade, also states these grievances:

The building lacks a library, teachers' rest room, art and music rooms and adequate storage space; the heating and ventilating systems cause extremes of heat or cold; lavatories for the two-story building are in the basement; narrow corridors, uneven wooden floors and poorly-designed stairways are potential dangers especially in case of fire or air raids.

The school, built 86 years ago, is attended by about 400 children in the first five grades. News item in Buffalo, N. Y., Evening News, October 8, 1952.

Disinfection of Books.—Ordinarily, little concern is given now to books as vectors of disease. At one time fumigation was commonly used but this method was found ineffective for the destruction of bacteria. School books should be put aside for 2-3 days and, preferably sunned. This readily dries the books and kills all common bacteria. *Journal of American Medical Association* March 22, 1952. Bulletin of Health Information, Public Schools, Denver.

* * * * *

Ultra Violet Lights Did Not Stop Colds.—Among the children or families of Pleasantville and Mt. Kisco in Westchester County, New York, in a careful three year study. This research report concludes: "From the data of acute respiratory illness observed in families during three school years, it is apparent that the introduction of ultra violet lights in the schools and other places where children congregate did not affect the illness rates. Also, there was no evidence that the seasonal or weekly incidence of such illness among school age children was affected in any way." *J. A. P. H. A.* —December 1950.

* * * * *

What's Funny About a Black Eye?—A simple black eye may often mask a more serious underlying condition. Even a light tap on the eye may cause retinal detachment which results in blindness of that part of the eye unless natural healing or surgery correct this condition. Fuzzy or cloudy vision following the injury is especially serious. Every black eye should be examined by a doctor aware of these complications. Cold compresses applied for 15 minutes every hour on the day of injury may prevent the eye from becoming blacker. *Medicine in the News*—June 1952.

* * * * *

Trends In Health Education.—Twenty-seven states now require health education in secondary schools by *law,* according to a recent Federal Government report. In six additional states, health education in secondary schools is required by *regulation of the state departments of education.* Of the 33 states, 25 report that health instruction is included in the curriculum as a *required subject. California's Health*—January 31, 1952.

* * * * *

The Cost of Killing Has Surpassed Even The Cost of Living. . . . . according to the Health Education Journal of the Los Angeles Public Schools.

"In the days of Julius Caesar it cost 75c to kill an enemy soldier. During Napoleon's time the cost rose to almost $3,000. The four years of World War I brought the cost to $21,000 and in World War II the figure rose to $35,000. June 1952.